

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(Please complete all blanks and initial where requested)

INMATE/PATIENT NAME (list previous names used) _____

Date of Birth _____

1. I authorize the Jefferson County Sheriff's Office (including Jail Medical Staff) to **release to/obtain from/exchange information with (circle one or all):**

Specify Individual, Agency or Organization

Address City State Zip Code

2. I understand that the specific type of information to be disclosed includes:

a. Records for the time period: _____ to _____
Beginning Date Ending Date

b. Records of related treatment that occur after the date of my signature _____ **may**, or
_____ **may not**, be released (initial one)

- c. Specific information requested: **(Initial one or more)**

_____ Reports of Counseling Sessions _____ Current Medications
_____ Psychiatric/Psychological Reports _____ History & Physical
_____ Lab _____ X-ray
_____ Other (specify): _____

The information to be released **may** include psychiatric, developmental disability, alcohol abuse, drug abuse, HIV test results, AIDS, or AIDS related disease diagnosis unless specified below:

3. Information from my health care record for the purpose of, or need for **(initial one or both):**

_____ Facilitate coordination of services between the named Individual, Agency or Organization and the Jefferson County Sheriff's Office (including Jail Medical Staff).

_____ Other (specify): _____

Re-disclosure Notice: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

4. Expiration Date: This authorization shall be valid for **one year** unless otherwise stated, or withdrawn through written notice to the **Jefferson County Sheriff's Office**.

Alternate date or event if not one year: _____

YOUR FEDERAL PRIVACY RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA) WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be Used or Disclosed—I understand that I have the right to inspect or copy the health information. I have authorized to be used or disclosed by this authorization form. I may arrange to inspect or copy the health information I have authorized to be used or disclosed by contact the Sheriff's Office. **Right to Receive a Copy of this Authorization**—I understand that if I agree to sign this authorization, I have a right to receive a signed copy of the form. **Right to Refuse to Sign this Authorization**—I understand that I am under no obligation to sign this form and the individual or organization listed above may not condition treatment or payment on my decision to sign this authorization, and that state or other federal law may allow this release for legal investigation or action without my signature. **Right to Withdraw this Authorization**—I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the disclosing individual, agency or organization listed above. I am aware that my withdrawal will not be effective until received by the disclosing individual, agency or organization and will not be effective regarding the uses and/or disclosures of my health information that the Jefferson County Sheriff's Office (including Jail Medical Department) has made prior to receipt of my withdrawal statement, and that state or other federal law may provide for use or disclosure if I withdraw this signed authorization.

I have read and understand the above and by my signature give consent to this release.

5. Patient Signature

Date

6. Authorized Signature/Relationship

Date

[If signed by other than patient, indicate relationship: ____ Parent of minor ____ Legal Guardian ____ Power of Attorney (initial one)]